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**BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA**

In the Matter of the Accusation Against,

HERNAN CARLOS ALVARADO, M.D.

PHYSICIAN'S AND SURGEON'S CERTIFICATE NO. AFE40827

RESPONDENT.

Case No. 16-2011-215237

**DEFAULT DECISION
AND ORDER**

[Gov. Code, §11520]

On August 23, 2011 an employee of the Medical Board of California ("Board") sent by certified mail a copy of Accusation No. 16-2011-215237, Statement to Respondent, Notice of Defense in blank, copies of the relevant sections of the California Administrative Procedure Act as required by sections 11503 and 11505 of the Government Code, and a request for discovery, to Hernan Carlos Alvarado, M.D. ("Respondent") at his address of record with the Board, 90 Shenango Street, Greenville, PA 16125. The certified mail receipt was signed and returned. (Accusation package, proof of service and return notification, Exhibit Package, Exhibit 1¹.)

There was no response to the Accusation. On September 26, 2011, an employee of the Attorney General's Office sent by certified and first class mail, addressed to Respondent his address of record a courtesy Notice of Default, advising Respondent of the service Accusation, and providing him with an opportunity to request relief from default. The green

¹ The evidence in support of this Default Decision and Order is submitted herewith as the "Exhibit Package."

1 certified mail receipt was signed and returned. (Exhibit Package, Exhibit 2, Notice of Default,
2 Proof of Service, return receipt.)

3
4 Respondent has not responded to service of the Accusation package or the Notice
5 of Default. He has not filed a Notice of Defense. As a result, Respondent has waived his right to
6 a hearing on the merits to contest the allegations contained in the Accusation.

7 **FINDINGS OF FACT**

8 **I.**

9 Linda K. Whitney is the Executive Director of the Board. The charges and
10 allegations in the Accusation were at all times brought and made solely in the official capacity of
11 the Board's Executive Director.

12 **II.**

13 On May 7, 1984, Physician's and Surgeon's Certificate No. A40827 was issued
14 by the Board to Hernan Carlos Alvarado, M.D. A Retired Status was granted at respondent's
15 request on June 1, 2011; the Certificate No. is now AFE40827. The certificate will expire on
16 November 30, 2011. (Exhibit Package, Exhibit 3, license certification.)

17 **III.**

18 On August 23, 2011, Respondent was served with an Accusation, alleging causes
19 for discipline against Respondent. The Accusation and accompanying documents were duly
20 served on Respondent. A courtesy Notice of Default was thereafter served on Respondent.
21 Respondent failed to file a Notice of Defense.

22 **IV.**

23 The allegations of the Accusation are true as follows:

24 On April 7, 2011 the Oregon Medical Board issued a Stipulated Order under
25 which Respondent surrendered his license to practice medicine in Oregon. The Stipulated Order
26 resolved allegations pertaining to Respondent's care and treatment of several patients: In June
27 2008 Respondent attempted to insert a Foley catheter in Patient A, an elderly man with cancer;
28

1 Respondent disregarded Patient A's complaints of pain and discomfort and his family's request
2 for pain medication. After he was unable to insert the catheter, Respondent threw the catheter
3 and his surgical gloves onto Patient A's abdomen and stated, "I've had it-I'm done with this" and
4 exclaimed to Patient A's son "Do it yourself." Patient B was diagnosed with a bladder tumor in
5 December 2007. The pathology report of a transurethral resection performed by Respondent on
6 January 24, 2008 was positive for cancer. Instead of immediately scheduling Patient B for
7 additional studies to stage the cancer, Respondent delayed two months to re-biopsy and stage
8 Patient B, who had an aggressive, high grade tumor. On December 16, 2007, Respondent
9 performed an outpatient vasectomy on Patient C. Respondent ignored Patient C's complaints of
10 acute pain and went ahead with the procedure. In 2007, Respondent treated Patient D, a 70 year
11 old woman, for a suspicious renal mass. Respondent removed the left kidney. Pathology
12 revealed a TCCa, but Respondent but did not attempt to remove the left ureter, and failed to
13 closely monitor Patient D postoperatively for signs of recurrence. In 2007 Respondent performed
14 a cystocele (fallen bladder) repair with Perigee mesh and a urinary incontinence correction for
15 Patient E. Shortly after the surgery Patient E was involved in an automobile accident and
16 complained to Respondent of urinary urgency, frequency and nocturia. Several months later the
17 patient complained of ongoing symptoms and Respondent found an area of exposed mesh in the
18 vaginal wall. Respondent prescribed vaginal estrogen cream in the face of persistent mesh
19 erosion and failed to offer surgical intervention to correct the exposed mesh. (A copy of the
20 Stipulated Order issued by the Oregon Medical Board is attached to the Accusation, Exhibit
21 Package, Exhibit 1.)

22 DETERMINATION OF ISSUES

23 I.

24 Pursuant to the foregoing Findings of Fact, Respondent's conduct and the action
25 of the Oregon Medical Board constitute cause for discipline within the meaning of Business and
26 Professions Code sections 2305 and 141(a).

27 ///

1 **DISCIPLINARY ORDER**

2 Physician's and Surgeon's certificate No. AFE40827 issued to Hernan Carlos
3 Alvarado, M.D. is hereby **REVOKED**.

4 Respondent shall not be deprived of making a request for relief from default as set
5 forth in Government Code section 11520(c) for good cause shown. However, such showing must
6 be made in writing by way of a motion to vacate the default decision and directed to the Medical
7 Board of California at 2005 Evergreen Street, Suite 1200, Sacramento, CA 95815 within seven
8 (7) days of the service of this Decision.

9 This Decision will become effective November 23, 2011

10 It is so ordered on October 24, 2011.
11

12 MEDICAL BOARD OF CALIFORNIA
13 DEPARTMENT OF CONSUMER AFFAIRS
14 STATE OF CALIFORNIA

15 By 

16 LINDA K. WHITNEY
17 Executive Director
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1 KAMALA D. HARRIS
Attorney General of California
2 JOSE R. GUERRERO
Supervising Deputy Attorney General
3 JANE ZACK SIMON
Deputy Attorney General [SBN 116564]
4 455 Golden Gate Avenue, Suite 11000
San Francisco, CA 94102-7004
5 Telephone: (415) 703-5544
Fax: (415) 703-5480
6 E-mail: Janezack.simon@doj.ca.gov
Attorneys for Complainant
7 *Medical Board of California*

FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO August 23, 2011
BY: J. Telehan ANALYST

8
9 **BEFORE THE**
MEDICAL BOARD OF CALIFORNIA
10 **DEPARTMENT OF CONSUMER AFFAIRS**
11 **STATE OF CALIFORNIA**

12 In the Matter of the Accusation Against:
13
14 **HERNAN CARLOS ALVARADO, M.D.**
90 Shenango Street
Greenville, PA 16125

15
16 Physician's and Surgeon's
17 Certificate No. AFE40827

18 Respondent.
19

Case No. 16-2011-215237

A C C U S A T I O N

20
21 The Complainant alleges:

22 1. Complainant Linda K. Whitney is the Executive Director of the Medical
23 Board of California, Department of Consumer Affairs, and brings this Accusation solely in her
24 official capacity.

25 2. On May 7, 1984, Physician's and Surgeon's Certificate
26 No. A40827 was issued by the Medical Board of California (Board) to Hernan Carlos Alvarado,
27 M.D. (Respondent.) A Retired Status was granted at Respondent's request on June 1, 2011; the
28

1 Certificate No is now AFE 40827. The certificate is renewed and current with an expiration date
2 of November 30, 2011.

3 **JURISDICTION**

4 3. This Accusation is brought before the Medical Board of California¹, under
5 the authority of the following sections of the California Business and Professions Code ("Code")
6 and/or other relevant statutory enactment:

7 A. Section 2227 of the Code provides that the Board may revoke,
8 suspend for a period not to exceed one year, or place on probation, the license of any
9 licensee who has been found guilty under the Medical Practice Act, and may recover the
10 costs of probation monitoring.

11 B. Section 2305 of the Code provides that the revocation, suspension,
12 or other discipline, restriction or limitation imposed by another state upon a license to
13 practice medicine issued by that state, that would have been grounds for discipline in
14 California under the Medical Practice Act, constitutes grounds for discipline for
15 unprofessional conduct.

16 C. Section 141 of the Code provides:

17
18 "(a) For any licensee holding a license issued by a board under
19 the jurisdiction of a department, a disciplinary action taken by another state, by
20 any agency of the federal government, or by another country for any act
21 substantially related to the practice regulated by the California license, may be
22 ground for disciplinary action by the respective state licensing board. A certified
copy of the record of the disciplinary action taken against the licensee by another
state, an agency of the federal government, or by another country shall be
conclusive evidence of the events related therein.

23 "(b) Nothing in this section shall preclude a board from applying
24 a specific statutory provision in the licensing act administered by the board that
provides for discipline based upon a disciplinary action taken against the licensee
by another state, an agency of the federal government, or another country."

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27 ¹. The term "Board" means the Medical Board of California; "Division of Medical
Quality" shall also be deemed to refer to the Board.

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FIRST CAUSE FOR DISCIPLINE

(Discipline, Restriction, or Limitation Imposed by Another State)

4. On April 7, 2011 the Oregon Medical Board issued a Stipulated Order regarding Respondent's license to practice medicine in Oregon. The Stipulated Order resolved allegations pertaining to Respondent's care and treatment of several patients: In June 2008 Respondent attempted to insert a Foley catheter in Patient A, an elderly man with cancer; Respondent disregarded Patient A's complaints of pain and discomfort and his family's request for pain medication. After he was unable to insert the catheter, Respondent threw the catheter and his surgical gloves onto Patient A's abdomen and stated, "I've had it-I'm done with this" and exclaimed to Patient A's son "Do it yourself." Patient B was diagnosed with a bladder tumor in December 2007. The pathology report of a transurethral resection performed by Respondent on January 24, 2008 was positive for cancer. Instead of immediately scheduling Patient B for additional studies to stage the cancer, Respondent delayed two months to re-biopsy and stage Patient B, who had an aggressive, high grade tumor. On December 16, 2007, Respondent performed an outpatient vasectomy on Patient C. Respondent ignored Patient C's complaints of acute pain and went ahead with the procedure. In 2007, Respondent treated Patient D, a 70 year old woman, for a suspicious renal mass. Respondent removed the left kidney. Pathology revealed a TCCa, but Respondent but did not attempt to remove the left ureter, and failed to closely monitor Patient D postoperatively for signs of recurrence. In 2007 Respondent performed a cystocele (fallen bladder) repair with Perigee mesh and a urinary incontinence correction for Patient E. Shortly after the surgery Patient E was involved in an automobile accident and complained to Respondent of urinary urgency, frequency and nocturia. Several months later the patient complained of ongoing symptoms and Respondent found an area of exposed mesh in the vaginal wall. Respondent prescribed vaginal estrogen cream in the face of persistent mesh erosion and failed to offer surgical intervention to correct the exposed mesh. A copy of the Stipulated Order issued by the Oregon Medical Board is attached hereto as Exhibit A.

5. Respondent's conduct and the action of the Oregon Medical Board as set forth in paragraph 4, above, constitute unprofessional conduct within the meaning of section 2305 and conduct subject to discipline within the meaning of section 141(a).

PRA YER

WHEREFORE, the complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number AFE40827 issued to respondent Hernan Carlos Alvarado, M.D.;
2. Revoking, suspending or denying approval of the respondent's authority to supervise physician assistants;
3. Ordering respondent, if placed on probation, to pay the costs probation monitoring; and
4. Taking such other and further action as the Board deems necessary and proper.

DATED: August 23, 2011.

LINDA K. WHITNEY
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California

Complainant

Exhibit A

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1.

The Oregon Medical Board (Board) is the state agency responsible for licensing and disciplining certain health care providers, including physicians, in the State of Oregon.

Hernan Carlos Alvarado, MD (Licensee) holds an inactive license to practice medicine in the State of Oregon.

2.

3.

3.1 Patient A was a 95-year-old male with a history of prostate and bladder cancer. Patient A was admitted to a Roseburg hospital on June 10, 2008, for treatment of renal failure. Patient A was unable to void his bladder. Ultrasound tests reflected that Patient A had significant post-void residual urines. Licensee ordered the insertion of a Foley catheter. On June 16, 2008, a nurse prepped Patient A for the procedure. Licensee entered the hospital room with a urology consultant to insert the catheter into the patient's penis. Licensee attempted to insert the catheter, which caused Patient A to cry out in pain. With each attempt, Patient A cried

1 out in severe discomfort, while blood extruded from the penis. Patient A's adult son, who was
2 present in the hospital room watching the procedure, asked that pain medication be provided for
3 his father. The attending nurse offered to get the analgesics. Licensee ignored the request and
4 the nurse's offer and informed them that inserting a catheter is not a painful procedure. Patient A
5 continued to moan in pain. Licensee was observed trying to force the catheter up the penis, only
6 causing more cries of distress from Patient A. Finally, Licensee pulled the catheter out from the
7 bloody penis, threw the catheter and his surgical gloves onto Patient A's abdomen, stated: "I've
8 had it—I'm done with this" (or words to that effect). He subsequently exclaimed: "Do it
9 yourself" to Patient A's son and left the hospital room. Licensee continues to deny that Patient
10 A's cries of pain were attributable to his efforts to insert the catheter.

11 3.2 Patient B, a 67-year-old male, was diagnosed with a bladder tumor on December
12 13, 2007. Patient B was referred by the diagnosing physician to Licensee for treatment. Patient
13 B met with Licensee in early January 2007 and was subsequently scheduled for surgery. On
14 January 24, 2008, Licensee performed a transurethral resection of the bladder tumor on Patient
15 B. The pathology report was positive for cancer—reflecting an invasive flat urothelial
16 carcinoma, high grade, with background urothelial carcinoma in situ. The carcinoma was seen
17 invading into fragments of smooth muscle tissue. Instead of immediately scheduling Patient B
18 for additional biopsies and ordering studies to stage the cancer, Licensee waited until March 10,
19 2008, to have Patient B undergo a CT scan of the pelvis with contrast. The CT scan indicated
20 that the bladder carcinoma was advancing. Licensee took additional biopsies on March 20,
21 2008, resulting in a final diagnosis of invasive, flat urothelial carcinoma, high grade, with
22 invasion into the muscularis propria. Patient B subsequently went to Oregon Health Science
23 University for treatment. Licensee's two month delay to re-biopsy and restage Patient B, who
24 had an aggressive, high grade tumor, did not conform to the standard of care and subjected this
25 patient to the risk of harm and to the cancer progressing.

26 3.3 Patient C, a 39-year-old male, presented to Licensee on December 16, 2007, for
27 an outpatient vasectomy. Licensee administered a local anesthetic by injections prior to

1 conducting the procedure. Patient C complained of acute pain, but Licensee dismissed Patient
2 C's complaints and proceeded with the procedure. Licensee's conduct is considered
3 inappropriate and insensitive towards a patient's pain.

4 3.4 Patient D, a 70-year-old female, underwent a computed tomography (CT) scan of
5 the abdomen and pelvis on May 9, 2007 that showed a left renal pelvic mass. Patient D
6 presented to Licensee on May 27, 2007, for follow up. Licensee reviewed the CT scan and
7 found that it showed a centrally located round mass in the middle of the left renal pelvis,
8 suspicious for transitional cell carcinoma (TCCa). On June 15, 2007, Licensee performed a
9 cystoscopy and left ureteroscopy on Patient D that confirmed the finding of a renal pelvic mass
10 (bleeding), which was suspicious for a TCCa, although a biopsy was not obtained. On July 13,
11 2007, Licensee performed a left radical nephrectomy (removal of the left kidney) on Patient D
12 using a midline surgical approach. The pathology revealed a TCCa. Licensee did not attempt to
13 remove the left ureter in its entirety. Patient D was discharged on postoperative day five.
14 Licensee saw Patient D in follow up on July 19 and August 21, 2007. Patient D underwent a CT
15 scan of the abdomen on November 21, 2007. Licensee subsequently saw Patient D on
16 November 28, 2007, and informed her that he planned to see her again in six months. Patient
17 D's understanding was that she had been "cured." Patient D was seen by another urologist in
18 June 2009 and underwent a diagnostic cystoscopy. This revealed numerous focal papillary
19 recurrences of transitional cell tumor in her bladder as well as gross tumor spilling out of her left
20 ureteral orifice, which had not been resected by Licensee at her initial surgery in 2007. Patient D
21 underwent a complete left urectectomy and resection and fulguration of her bladder recurrences
22 in August of 2009. A subsequent bone scan indicated that the TCCa had spread to her bones.
23 She was treated with radiation therapy. Licensee's failure to remove the entire ureter at the time
24 he removed the left kidney in the face of TCCa of the renal pelvis and his failure to closely
25 monitor Patient D postoperatively for signs of recurrence with surveillance cystoscopy and
26 ureteroscopy was grossly negligent and exposed this patient to the risk of harm.

27 ///

3.5 Patient E, a 49-year-old female, first presented to Licensee on April 26, 2007 with a history of urinary incontinence. On June 21, 2007, Licensee performed a cystocele (fallen bladder) repair with Perigee mesh and a urinary incontinence (SUI) correction with Monarc transorturator tape. Ten days later, Patient E was involved in a motor vehicle accident and complained of urinary urgency, frequency and nocturia. On or about October 30, 2007, Licensee conducted a cystometrogram at which time Licensee commented that there was no sign of any mesh extrusion. Licensee prescribed Solifenacin (Vesicare) and provided her with a three week supply. Patient E returned on March 14, 2008 and complained of a scratchy feeling in the vaginal area since surgery. Licensee found an area of exposed mesh in the right anterior vaginal wall. Licensee recommended that she use vaginal estrogen cream. Licensee saw Patient E again on June 2, 2008, and re-examined the exposed vaginal mesh. Patient E wanted to have her surgery redone. Licensee urged Patient E to continue treating the area with the Premarin vaginal cream that he had prescribed. The problem did not resolve. Patient E sought care with another physician, and on August 24, 2009, she underwent surgery with this other physician, to repair the mesh erosion. A 1 x 2 cm area of mesh exposure was noted. The mesh was also noted to be bunched and overlapped in roughly three layers and placed much more proximally than the mid-urethral locale ordinarily employed. Licensee's reliance upon estrogen cream in the face of persistent mesh erosion and failure to offer surgical intervention to correct the exposed mesh breached the standard of care.

4.

Licensee and the Board agree to close this investigation with this Stipulated Order in which Licensee agrees to surrender his license while under investigation, consistent with the terms of this Order. Licensee admits and the Board finds that Licensee's conduct described in paragraph 3 violated ORS 677.190(1)(a), (b), and (c) unprofessional or dishonorable conduct, as defined in ORS 677.188(4)(a) and ORS 677.190(13), gross or repeated acts of negligence. Licensee understands that he has the right to a contested case hearing under the Administrative

1 Procedures Act (chapter 183), Oregon Revised Statutes and fully and finally waives the right to a
2 contested case hearing and any appeal therefrom by the signing of and entry of this Order in the
3 Board's records. Licensee understands that this document is a public record and is reportable to
4 the National Practitioners Data Bank, the Healthcare Integrity and Protection Data Bank and the
5 Federation of State Medical Boards.

6 5.

7 Licensee and the Board agree to resolve this matter by the entry of this Stipulated Order
8 subject to the following conditions:

9 5.1 Licensee surrenders his license to practice medicine while under investigation.
10 This surrender of license becomes effective June 1, 2011. As of that date, Licensee shall cease
11 practicing medicine entirely.

12 5.2 Licensee agrees to never re-apply for a license to practice medicine in Oregon.

13 5.3 Licensee stipulates and agrees that any violation of the terms of this Order would
14 be grounds for further disciplinary action under ORS 677.190(17).

15
16 IT IS SO STIPULATED this 22 day of February, 2011.

17
18 Signature Redacted

19
20 HERNAN CARLOS ALVARADO, MD

21 IT IS SO ORDERED this 7th day of April, 2011.

22 OREGON MEDICAL BOARD
23 State of Oregon

24
25 Signature Redacted

26 RALPH A. AYATES, DO
27 BOARD CHAIR